

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

318

1003

8602-63-033641

STATE FILE NUMBER

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

Primary Registration District No.

Registrar's No.

FILED AUG 29 1963

VS 300
Rev. 4/59

DATE AMENDED

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

ITEM NO. SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

| | | | |
|--|---|--|--|
| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Missouri b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN St. Louis | | Length of stay in 1b 4 days | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION St. Louis-Little Rock Hospitals, Inc. | | c. CITY OR TOWN St. Louis | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | d. STREET ADDRESS 1919 So. Grand Ave (Saum Hotel) | |
| 3. NAME OF DECEASED (Type or print) First Phillip Middle A. Last Freundlich | | 4. DATE OF DEATH Month August Day 23 Year 1963 | |
| 5. SEX Male | 6. COLOR OR RACE White | 7. Married <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> | 8. DATE OF BIRTH 10-28-1872 |
| 9. AGE (last birthday) 90 | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY Dry Goods Man Boonville, Ind. | |
| 11. BIRTHPLACE (City and state or country) U.S.A | | 12. CITIZEN OF WHAT COUNTRY | |
| 13a. FATHER'S NAME John Jacob Freundlich | | 13b. MOTHER'S MAIDEN NAME Eva Lutz | |
| 14. NAME OF HUSBAND OR WIFE Wife- Caroline | | 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of) | |
| 16. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Congestive Heart Failure - CHLS Conditions, if any, which gave rise to above cause (a), stating the underlying cause last: DUE TO (b) Arteriosclerotic Heart Disease DUE TO (c) 420.0 | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) Benign Plostatic Hypertrophy - Suprapubic Prostatectomy | | PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.) | |
| 20c. TIME OF INJURY Hour a.m. Month, Day, Year | 20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | |
| 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.) | 20f. CITY, TOWN, OR LOCATION COUNTY STATE | | |
| 21. I attended the deceased from Aug 19-63 to Aug 23-63 and last saw him alive on 8-23-63 | | Death occurred at 2 A.M. m on the date stated above, and to the best of my knowledge, from the causes stated. | |
| 22a. SIGNATURE (Degree or title) Ross Des Blends M.D. | 22b. ADDRESS 1755 So Grand Blvd | 22c. DATE SIGNED 8-24-63 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE 8-26-63 | 23c. NAME OF CEMETERY OR CREMATORY Calvary | 23d. LOCATION (City, town, or county) (State) St. Louis Mo. |
| 24. FUNERAL DIRECTOR Kriegshauser | ADDRESS 4228 So Kingshyway | 25. DATE RECD. BY LOCAL REG. AUG 26 1963 | 26. REGISTRAR'S SIGNATURE Earl Smith M.D. |

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK
OR
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

James P. Quinn

Licensed Embalmer No. 4527

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.